Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Division regarding a medical fee dispute between the requestor and the respondent named above. This dispute was received on 1/2/04.

I. DISPUTE

Whether there should be reimbursement for CPT codes 72285 -26 (x3), 62291 -59 (x3), and 76005 for date of service 9/12/03.

II. RATIONALE

The services in dispute were denied as "L-Not Treating Doctor Approved" and "R-Extent of Injury." The "L" denial code was retracted, by the Carrier, per their letter dated 12/16/03.

The Requestor states, on the Table of Disputed Services, "Referred by treating doctor, ___MD."

The Carriers position statement, titled, 'Respondent's Rationale For Maintaining Reduction Or Denial,' states, "The bill was denied as (R) extent of injury. TWCC 21 (x5) have been filed which dispute many conditions." Copies of the TWCC 21's (5) were received by Medical Dispute Response, identifying the following conditions as not related: cervical spondylosis, spur, stenosis, connective tissue disorder, rheumatoid arthritis, inflammatory arthritis, right wrist, right hand, and fingers.

Review of the submitted HCFA's identify diagnosis codes 722.2 and 723.4 for which treatment was rendered. These diagnosis codes are not included in the TWCC 21's, therefore, billed services will be reviewed in accordance with Commission Rule 134.202 (b), Medical Fee Guideline, effective 8/1/03, states that, "For coding, billing, reporting, and reimbursement of professional medical services, Texas Workers Compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a services is provided with any additions or exceptions in this section." To determine the maximum allowable reimbursement (MAR) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications: Rule 134.202 (c) (1) states, "For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Surgery, Radiology, and Pathology. The conversion factor to be used for determining reimbursement in the Texas workers' compensation system is the effective conversion factor adopted by Centers for Medicare and Medicaid Services multiplied by 125%. For Anesthesiology services, the same conversion factor shall be used."

Partial reimbursement is recommended per Commission Rule 134.202, Medical Fee Guideline (effective 8/1/03). Reimbursement methodology is as follows:

DOS	CPT Code	Billed	Paid	EOB Denial Code	MAR$	Reference	Rationale:
9/12/03	62291 –59	$500.00	$0.00	L (was retracted by the Carrier) R (Review of the submitted HCFA's identify diagnosis codes 722.2 and 723.4 for which treatment was rendered. These diagnosis codes are not included in the TWCC 21's, therefore, billed services will be reviewed in accordance with Commission Rule 134.202 as a fee dispute)	N/A	Medicare Fee Guideline	62291 –59 has been billed by the Requestor 3 times. Requestor has failed to identify the primary procedure. On this basis MDR is unable to determine the appropriate rate of reimbursement as billed. No reimbursement recommended.
9/12/03	62291 –59	$500.00	$0.00		N/A		
9/12/03	62291 –59	$500.00	$0.00		N/A		
9/12/03	72285 –26	$300.00	$0.00		$55.31 x 125%	Rule 134.202 and Medicare Fee Guideline	Reimbursement is recommended in the amount of $69.14.
9/12/03	72285 -26	$300.00	$0.00		$0.00	Medicare Fee Guideline	Per Medicare Guidelines, cannot bill more than once. No reimbursement recommended.
9/12/03	72285 –26	$300.00	$0.00		$0.00	Medicare Fee Guideline	
9/12/03	76005 -26	$250.00	$0.00		$27.56 x 125%	Rule 134.202 and Medicare Fee Guideline	Reimbursement is recommended in the amount of $34.45.
Total							Total amount recommended for reimbursement, $103.59.

III. DECISION & ORDER

Based upon the review of the disputed healthcare services within this request, the Division has determined that the requestor is entitled to reimbursement in the amount of $103.59. Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Division hereby ORDERS the Respondent to remit $103.59 plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this Order.

The above Findings, Decision and Order are hereby issued this 30th day of April 2004.

Terri Chance
Medical Dispute Resolution Officer
Medical Review Division

TC/tc